

Module Four

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Healthcare Fraud and Prevention

Purpose

This Module defines and identifies fraud committed against Medicare, Medicaid, and Healthcare in general. It also gives ways to prevent and report fraud committed against Medicare, Medicaid, and Healthcare.

Objectives

By the end of this training session, you will be able to:

- Define fraud
- Identify the types of fraud (Medicare, Medicaid, and Healthcare)
- Recognize common schemes associated with fraud
- Recognize fraud and ways to prevent it
- Identify reporting procedures

Group Resume

WHO

are we and

WHERE

do we come from??

What is Fraud?

Intentionally
Knowledgably
And Willingly

Trying to or actually getting
Service or payments through
Dishonest Means!

Medicare Fraud

Ripping off Medicare

I'll tell you how they do it later!!



Medicare Abuse

Different from Medicare Fraud

- Fraud is intentional
- Abuse is unintentional

What is Medicaid Fraud?

- Medicaid fraud is perpetrated by providers.
- Medicaid fraud is a huge criminal enterprise. The estimated cost of Medicaid Fraud to the tax payer is over \$10 billion a year.

How Much Medicaid Fraud Cost

- Each year it is estimated that 10% of the total Medicaid Budget gets wasted in fraudulent activity by providers. In Arkansas that equates to:

<u>SFY Year</u>	<u>Medicaid Budget</u>	<u>Fraud estimated</u>
2004	\$2,711,038,010	\$271,103,801
2003	\$2,467,689,636	\$246,768,963
2002	\$2,292,624,463	\$229,262,446

Arkansas Attorney Generals Office, Medicaid Department.

Medicaid Fraud Recoveries

- Arkansas Medicaid Fraud recoveries through fines, restitution, civil settlements and penalties from 1998-2003:

<u>FY</u>	<u>Unit Cost</u>	<u>Convictions</u>	<u>Recoveries</u>
2003	\$1,560,000	10	\$2,029,782
2002	\$1,508,000	19	\$912,148
2001	\$1,408,000	21	\$731,413
2000	\$1,391,000	22	\$489,139
1999	\$1,373,000	33	\$360,897
1998	\$1,267,000	36	\$1,903,392

Case Narrative

- A nursing home entered into a civil settlement agreement to pay the Arkansas MFCU \$10,000 for patient negligence resulting in a death. A patient sustained injuries, including fractures to his skull, upper extremities and mouth, while allegedly being transferred from his bed to the bathroom by an employee. The patient was transferred to a hospital where he later died of innercranial hemorrhage and closed-head injury. Investigators found that the nursing home was negligent in the care of the patient.

How they do it

Fraud Schemes



Billing Fraud

- Billing for services not rendered also known as phantom billing.
- Examples:
 - Medical services for procedures that were not actually performed (x-rays or lab tests).
 - Goods that were not provided (extra prescriptions).
 - Care allegedly given to patients who are no longer eligible, have transferred to another facility or who have died (phantom patients).

Double Billing

- Billing multiple times for the same services to the same patient.
- A provider bills both Medicaid or Medicare and the recipient (or private insurance company) for the health care service or goods, or two providers bill for the same service.

Unnecessary Medical Services

- Billing for services that are not medically necessary.
 - Examples of services:
 - Physical Therapy
 - Durable Medical Equipment
 - Unnecessary prescriptions
 - Unneeded equipment
 - Laboratory test and procedures that have no medical value or purpose

Kickbacks

- Occur when providers exchange a percentage of a sum of money to other providers who refer patients to their business.
- This includes:
Medical Suppliers, Home Health Care Agencies, Pharmacies, Hospitals, Therapist or other Medicaid providers.

Upcoding

- Billing for a more expensive or Medicare/Medicaid covered item when a less expensive, non-covered item was provided.
- Altering Claim forms to obtain higher payment amount.
- Misuse of the standardized system of numerical codes for patient services to increase the bill by exaggerating or even falsely representing what medical conditions were present and what services were provided.

Overutilization

- Unnecessary services are provided to a Medicare/Medicaid recipient for the purpose of billing the Medicare/Medicaid program.
- For example, a provider orders blood test each time the recipient comes to the office.

Unbundling

- Billing related services separately to charge a higher amount than if they are combined and billed as one service, group of services or panel of services.

Drug Substitution/Diversion

- A pharmacist fills a recipient's prescription with a generic drug or an over the counter drug but bills Medicare/Medicaid for a more expensive name brand drug.
- A pharmacist shortchanges the client on the number of pills but bills Medicare/Medicaid for the full amount.
- Theft of medications by nursing home staff or hospital employee.

Falsification of Records

- Many schemes to defraud Medicare/Medicaid involve falsification of patient records to support improper billing.
- Staff or employees writing reports in pencil so they can be doctored at a later date.

False Cost Reporting

- Billing or old items as if they were new.
- Billing for more hours than there are in the day.
- Overcharging for health care services or goods that were provided.
- Charging Medicare/Medicaid for personal expenses that have nothing to do with caring for Medicare/Medicaid client.
- Concealing ownership in a related company or using false credentials.

Medicaid Abuse and Neglect

Long term care facilities

The Federal regulations for long-term care facilities state that “each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being.”

Adult Abuse Act

The authority to protect nursing home residents derives from the Adult Abuse Act, which forbids abuse, exploitation and/or neglect of the elderly.

Adult Abuse Defined

Any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered or impaired adult, including sexual abuse.

Any intentional or demeaning act which subjects an endangered or impaired adult to ridicule or psychological injury in a manner likely to provoke fear or alarm.

Neglect Defined

- Negligently failing to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision or medical services to an endangered or impaired adult.
- Negligently failing to report health problems or changes in health problems or health conditions of an endangered adult
- Negligently failing to carry out a prescribed treatment plan.

Exploitation Defined

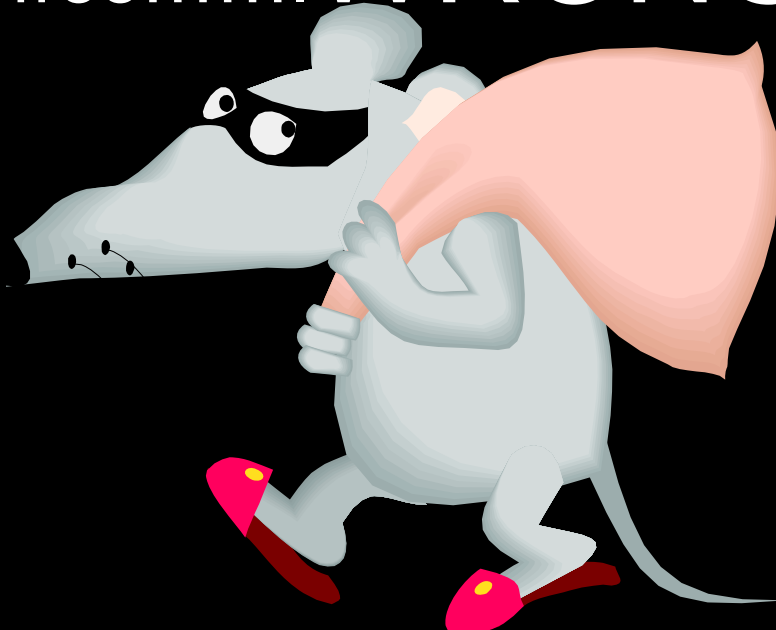
- Exploitation is the illegal use or management of an endangered or impaired adult's funds, assets or property or the use of an endangered or impaired adult's power of attorney or guardianship or person for the profit or advantage of themselves or another.

Case Narrative

- The Arkansas Attorney General's Office reached a \$1.5 million settlement with Beverly Enterprises, Inc. after an 18 month investigation found evidence of neglect, injuries and failure to provide nursing care and treatment for vulnerable nursing home residents. This behavior is considered Medicaid fraud. This settlement will result in nearly \$6 million of additional funding for Arkansas' Medicaid programs.

Clues

- Nothing is FREE! If a provider wants your Medicare/Medicaid number but says the service is free.....**WRONG!**



CLUES

- Medicare or Medicaid WANTS you to have the service or item.... Your doctor decides what you need-not a salesman!
- The salesman (provider) knows how to get *Medicare or Medicaid* to pay for it.....they are scamming you!!!

Clues

- The more tests they provide, the cheaper they are (Wrong again-MORE is MORE!)

Besides-there are no co-payments on Labs!!!

CLUES

- The salesmen represent Medicare or Medicaid. No they don't-they represent their company!!!!
- Neither Medicare nor Medicaid use telemarketers or door-to-door salesman to “sell” anything!!!

HINT

- Get on the do not call list.....

www.donotcall.gov

1-888-382-1222

Telemarketing Fraud hotline

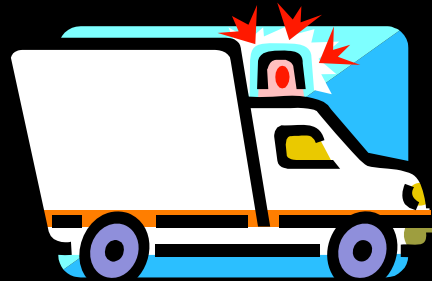
1-800-876-7060

More CLUES

- Free consultations-remember nothing is FREE!
- Pressure or Scare Tactics!!!

Ambulance Fraud CLUES

- Billing for advance life support services when basic life support services were provided.





CLUES

- Ambulance service acting as a shuttling service. They are not Taxis!!

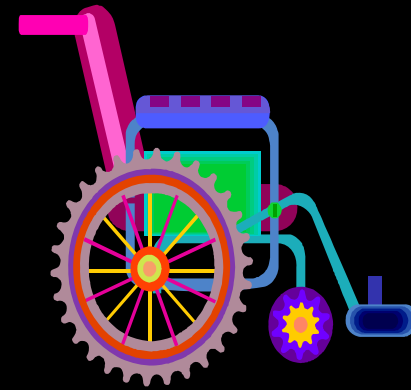




- Billing for more miles than are actually traveled.

Durable Medical Equipment

- Offering free equipment in exchange for your number. Remember, **NOTHING IS FREE!**
- Power wheelchairs when you don't even need one-FREE!



MORE DME CLUES

- Doctor's order unnecessary equipment-they are probably getting kickbacks!
- You no longer need the equipment but the supplier refuses to pick it up-THEY ARE STILL BILLING FOR IT!

Home Health Care Clues

- Billing for beneficiaries are not homebound!
- Unfair marketing practices like offering incentives....transportation, groceries, etc...
- Billing for more hours than are provided.
- Billing for housekeeping or custodial services.
- Billing for services not rendered!

Hospice Clues

- Duplicate claims receiving payment from both Medicare and Medicaid.
- Filing under the spouse's number.

Hospital Fraud CLUES

- Billing for out-patient services
- Billing for more services than were provided
- Upcoding the diagnosis
- Billing for patients under observation even after they have been admitted
- Billing for unnecessary procedures
- Kickbacks

Hospital Fraud CLUES

- Double Billing

Remember-Know your Rights!



Laboratory CLUES

- Charging a co-payment when there isn't one!
- Rolling Labs who offer free testing in exchange for your number(s). *Nothing is free!*
- Tests not ordered by your doctor.
- Falsified results of tests.

Mental Health Fraud

- Misrepresenting length of counseling sessions.
- Sessions by unlicensed staff.

Nursing Home facility CLUES

- Gang visits-when doctors bill for services for all or nearly all of the residents without even seeing them!
- Billing social activities as psychotherapy.
- Billing for supplies not provided to the patient.

The Detectives are on the Prowl

What to look for!!



Review your MSNs and Bills

- For services not provided
- Duplicate Claims
- Upcoding
- Accurate dates
- Services billed match what you received

Reporting Medicare Fraud

Medicare Fraud

Part A 1-877-356-2368

Part B 1-800-482-5525

Reporting Medicaid Fraud

- If you have reason to believe someone is abusing a Medicaid recipient or private pay resident in a Medicaid funded long term care facility or is defrauding the Arkansas Medicaid program, contact the Arkansas Attorney General's Medicaid Fraud Control Unit at:

Toll Free - 1-866-810-0016

Or

Locally - (501) 682-7760

Reporting Medicaid Fraud

- Report all suspected incidents of neglect or abuse of a resident of a long-term care facility to the DHS Office of Long Term Care at:

Toll Free – 1-800-582-4887

Reporting Medicaid Fraud

- To report suspected Medicaid Fraud contact the ASMP hotline at:

Toll Free – 1-866-726-2916

Reporting Medicaid Fraud

- Or contact the National Fraud Hotline at:

1-800-447-4847

When reporting suspected Fraud

- **Make sure to have the MSN in front of you as well as the following information:**
 - The beneficiary's Medicare Health Insurance Claim Number or Medicaid number,
 - The name of the provider and any identifying number you might have,
 - The item or service you are questioning,
 - The date of service,
 - The amount approved and paid by Medicaid,
 - The Date and explanation of benefits (EOB and MSN)
 - The problem or reason why you believe that Medicaid should not have paid.

Do you get it?

- Fraud or Not

And

WHY?



Someone comes to your door to selling Prescription Drug Plan Coverage?

Possible Fraud

- Do not give any PERSONAL information to a door to door salesman or telemarketer!

**Free stroke prevention testing in
exchange for your Number(s)**

FRAUD

Remember, nothing is free!!

Medicare and Medicaid say no BUT

- The provider knows how to get them to pay for it-

FRAUD

No means no-providers can't change that they are just lying to the programs!!

Let's Review

Questions????????